MassHealth

Billing Guide for Paper Claim Form No. 5

BG-5-CL (Rev. 07/07)

Executive Office of Health and Human Services
MassHealth
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Introduction

The following information describes in detail how to bill on the paper claim form no. 5. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for Claim Form No. 5.

General Instructions for Submitting Paper Claims

Claim Form No. 5

The following providers must use claim form no. 5 (Request for Payment - Physician Claim) when submitting paper claims to MassHealth:

- acute inpatient hospitals (for professional services provided by hospital-based physicians only);
- acute outpatient hospitals (for professional services provided by hospital-based physicians only);
- freestanding ambulatory surgery centers;
- hospital-licensed health centers (for professional services provided by hospital-based physicians only).
- independent diagnostic testing facilities;
- independent nurse midwives;
- independent nurse practitioners; and
- physicians.

To obtain supplies of claim form no. 5, submit a request to MassHealth at the address found in Appendix A of your MassHealth provider manual.

Preventive Care for Members Under 21

When billing for preventive care, physicians, independent nurse practitioners, and independent nurse midwives may use claim form no. 5 or claim form no. 4. (See Appendix W of your provider manual for the Early and Periodic Screening, Diagnosis and Treatment Schedule for well-child care.) If a member is under 21, has third-party liability, and the provider has not billed the other insurer, providers should bill these services using claim form no. 4, so that the claim is not denied because the member has other insurance that does not pay for these preventive services.

Entering Information on Claim Form No. 5

Follow these guidelines when filling out the claim form.

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as “same as above.”

General Instructions for Submitting Paper Claims (cont.)

- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY format.

  Example: For a member born on February 28, 1960, the entry in Item 2 (Member's Date of Birth) would be as follows.

022860

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, §20) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) from another insurer to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the billing regulations in Subchapter 3 of your MassHealth provider manual.

Since the 90-day requirement applies to each claim line, the claim form must be received within 90 days from the earliest date of service on the form.

All services listed on a single claim line must have been provided in the same fiscal year. That is, if you are allowed to submit consecutive dates of service on a single claim line ("from and thru" billing), dates of service from the months of June and July should never appear on the same claim line.

For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

Claims for Members with Other Health Insurance Coverage

Special instructions for submitting claims for services furnished to members with health insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your provider manual for contact information. Additional information is also available in Subchapter 5 of your manual.

Where to Send Paper Claim Forms

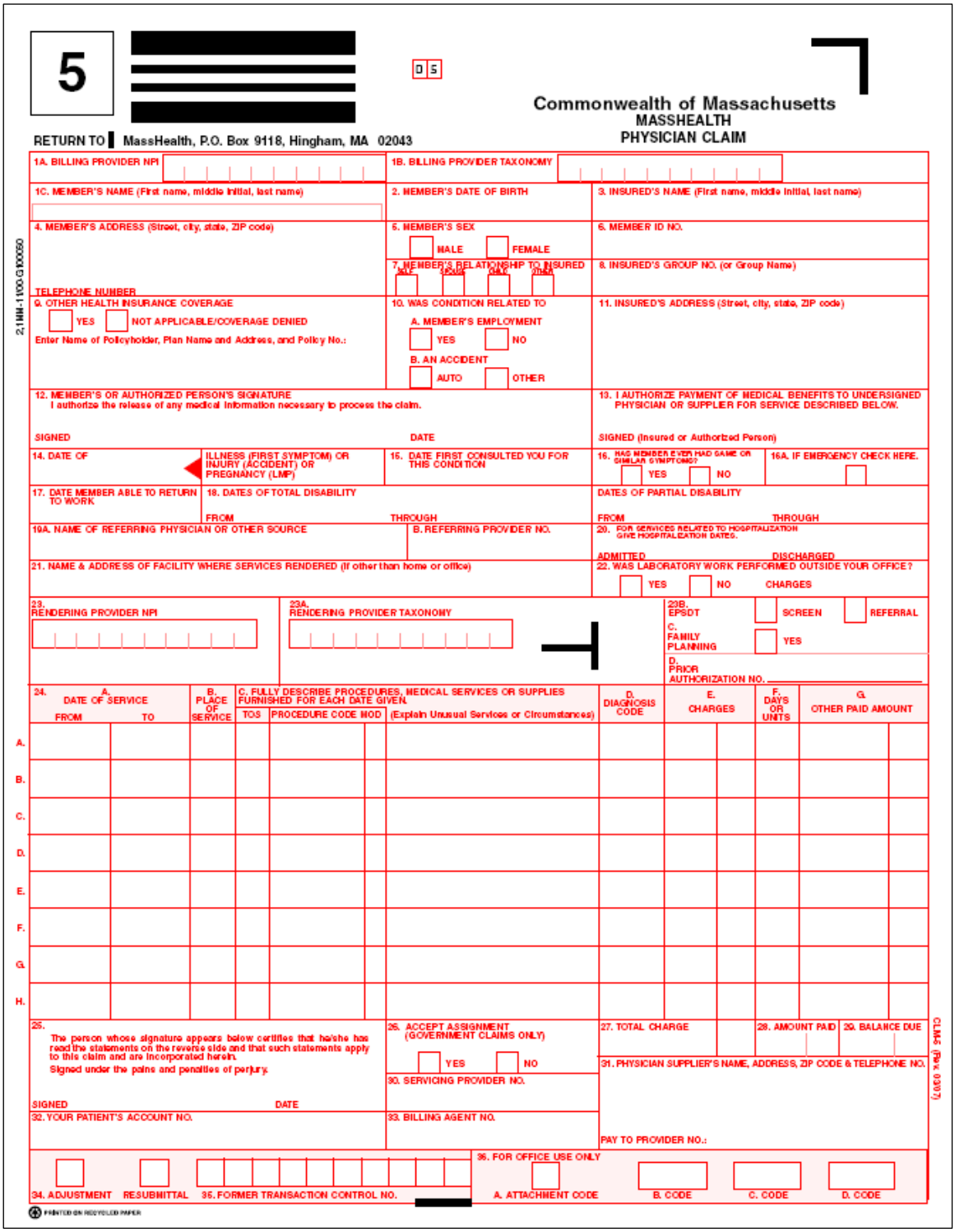
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete claim form no. 5, you can contact MassHealth Customer Service. Please refer to Appendix A for all MassHealth Customer Service contact information.

Item-by-Item Instructions for Claim Form No. 5

A sample claim form is shown below. Following this sample are completion instructions for each field on claim form no. 5.



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Commonwealth of Massachusetts
MASSHEALTH
PHYSICIAN CLAIM

RETURN TO MassHealth, P.O. Box 9118, Hingham, MA 02043

1A. BILLING PROVIDER NPI | 1B. BILLING PROVIDER TAXONOMY

1C. MEMBER'S NAME (First name, middle initial, last name) | 2. MEMBER'S DATE OF BIRTH | 3. INSURED'S NAME (First name, middle initial, last name)

4. MEMBER'S ADDRESS (Street, city, state, ZIP code) | 5. MEMBER'S SEX: MALE FEMALE | 6. MEMBER ID NO.

TELEPHONE NUMBER | 7. MEMBER'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER | 8. INSURED'S GROUP NO. (or Group Name)

9. OTHER HEALTH INSURANCE COVERAGE: YES NOT APPLICABLE/COVERAGE DENIED
Enter Name of Policyholder, Plan Name and Address, and Policy No.: | 10. WAS CONDITION RELATED TO: A. MEMBER'S EMPLOYMENT: YES NO; B. AN ACCIDENT: AUTO OTHER | 11. INSURED'S ADDRESS (Street, city, state, ZIP code)

12. MEMBER'S OR AUTHORIZED PERSON'S SIGNATURE
I authorize the release of any medical information necessary to process the claim.
SIGNED DATE | 13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.
SIGNED (Insured or Authorized Person)

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) | 15. DATE FIRST CONSULTED YOU FOR THIS CONDITION | 16. HAS MEMBER EVER HAD SAME OR SIMILAR SYMPTOMS? YES NO | 16A. IF EMERGENCY CHECK HERE.

17. DATE MEMBER ABLE TO RETURN TO WORK | 18. DATES OF TOTAL DISABILITY FROM THROUGH | DATES OF PARTIAL DISABILITY FROM THROUGH

19A. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | B. REFERRING PROVIDER NO. | 20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES. ADMITTED DISCHARGED

21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office) | 22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES NO CHARGES

23. RENDERING PROVIDER NPI | 23A. RENDERING PROVIDER TAXONOMY | 23B. EPSDT SCREEN REFERRAL | C. FAMILY PLANNING YES | D. PRIOR AUTHORIZATION NO.

24. A. DATE OF SERVICE FROM	TO	B. PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. TOS	PROCEDURE CODE	MOD	(Explain Unusual Services or Circumstances)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G. OTHER PAID AMOUNT
A.										
B.										
C.										
D.										
E.										
F.										
G.										
H.										

25. The person whose signature appears below certifies that he/she has read the statements on the reverse side and that such statements apply to this claim and are incorporated herein.
Signed under the pains and penalties of perjury.
SIGNED DATE

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES NO

27. TOTAL CHARGE | 28. AMOUNT PAID | 29. BALANCE DUE

30. SERVICING PROVIDER NO.

31. PHYSICIAN SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.

32. YOUR PATIENT'S ACCOUNT NO.

33. BILLING AGENT NO.

PAY TO PROVIDER NO.:

34. ADJUSTMENT RESUBMITTAL 35. FORMER TRANSACTION CONTROL NO.

36. FOR OFFICE USE ONLY
A. ATTACHMENT CODE B. CODE C. CODE D. CODE

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Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
1A	Billing Provider NPI	Enter your billing (pay-to) NPI.
1B	Billing Provider Taxonomy	Enter the taxonomy code applicable for the billing (pay-to) NPI number only if instructed to do so by MassHealth.
1C	Member's Name	Enter the name of the member receiving services.
2	Member's Date of Birth	Enter the member's date of birth in MMDDYY format.
3	Insured's Name	Leave this item blank.
4	Member's Address	Leave this item blank.
5	Member's Sex	Enter an "X" in the appropriate box to indicate the member's gender.
6	Member ID No.	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member ID number on the temporary MassHealth card may include an asterisk as the 10th character.
7	Member's Relationship to Insured	Leave this item blank.
8	Insured's Group No.	Leave this item blank.
9	Other Health Insurance Coverage	Enter an "X" in the appropriate box. If "Yes" is checked, enter the name of the policyholder, plan name and address, and policy number in the space indicated.
10	Was Condition Related to Member's Employment or an Accident	Complete this item only if the service was necessary because the member was involved in an accident. A – Member's Employment. Enter an "X" in the appropriate box to indicate whether the condition is employment related. B – An Accident. Enter an "X" in the appropriate box to indicate the type of accident.
11	Insured's Address	Leave this item blank.
12	Member's or Authorized Person's Signature	Leave this item blank.
13	I Authorize Payment...	Leave this item blank.
14	Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	If Item 10A was checked "Yes," or if either box in Item 10B was checked, enter the date of the accident or injury.
15	Date First Consulted You for This Condition	Leave this item blank.
16	Has Member Ever Had Same or Similar Symptoms?	Leave this item blank.

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
16A	If Emergency Check Here	*Physicians, Nurse Midwives, and Nurse Practitioners:* Enter an "X" in any of the following situations: • emergency care was provided; • emergency care was provided in a hospital emergency department to a member enrolled in the Primary Care Clinician (PCC) Plan; or • an emergency-department screening was provided to the member and the claim is for the screening fee. *All other providers:* Leave this item blank.
17	Date Member Able to Return to Work	Leave this item blank.
18	Dates of Total Disability Dates of Partial Disability	Leave this item blank.
19A	Name of Referring Physician or Other Source	*For members enrolled in the PCC Plan*: Enter the name of the member's PCC. *For radiology services for members not enrolled in the PCC Plan*: Enter the name of the referring provider. *For all other members*: Leave this item blank.
19B	Referring Provider No.	*For members enrolled in the PCC Plan*: Enter the seven-digit referral number of the member's PCC. This referral number can be obtained by contacting the PCC before providing the service. PCC names and telephone numbers are available from the Recipient Eligibility Verification System (REVS). Certain services do not require a PCC referral (for example, anesthesia, pathology, or family planning). See 130 CMR 450.118(J)(2). *For radiology services for members not enrolled in the PCC Plan*: Enter the seven-digit MassHealth provider number of the provider requesting the service. If the provider number is unknown, enter "9999990." *For all other members*: Leave this item blank.

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
20	For Services Related to Hospitalization Give Hospitalization Dates	Enter the admission and discharge dates for hospitalization-related services, if applicable.
21	Name & Address of Facility Where Services Rendered	Enter the name or location where the service was provided if other than an office setting or home setting, if applicable.
22	Was Laboratory Work Performed Outside Your Office?	Enter an "X" in the appropriate box to indicate if the laboratory work relating to services listed on the claim form was performed outside your office, if applicable.
23	Rendering Provider NPI	*Physicians, Nurse Midwives, and Nurse Practitioners:* If a group practice number is entered in Item 1A, enter the rendering (servicing) NPI.
23A	Rendering Provider Taxonomy	Enter the taxonomy code applicable for the rendering (servicing) provider's NPI only if instructed to do so by MassHealth.
23B	EPSDT	Enter an "X" in the box labeled "Yes" if the member is under 21 years of age and the services were provided as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening referral or related to a well-child visit provided in accordance with the EPSDT Schedule.
23C	Family Planning	Enter an "X" in the "Yes" box if the services were related to family planning.
23D	Prior Authorization No.	Enter the six-character prior-authorization (PA) number assigned by MassHealth, if applicable.
24A	Date of Service: From/To	Enter the date the service was provided in MMDDYY format. *For a single date of service*: In the "From" column, enter the date the service was provided in MMDDYY format. Leave the "To" column blank. *For consecutive dates of service*: In the "From" column, enter the first date of service. In the "To" column, enter the last date of service. Billing for consecutive dates of service on a single claim line is allowed for only certain services. For example, a physician may bill for hospital visits on successive days by entering the dates of service in the "From" and "To" boxes, but a physician may not bill for office visits on successive days on a single claim line.

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
24B	Place of Service	Enter the code from the list below that describes the place where the service was provided. 01 – office, facility, business location 02 – member's home 03 – inpatient hospital 04 – outpatient hospital 05 – emergency department 06 – nursing facility 07 – rest home 10 – school-based health center 99 – other location (If "99" is used, enter the name and address of the place of service in Item 21.)
24C	Fully Describe Procedures, Medical Services or Supplies Furnished for Each Date Given	
	TOS	Leave this item blank.
	Procedure Code	Enter the service code that corresponds to the service, item, or medication provided. See Subchapter 6 of the applicable provider manual for lists of payable and nonpayable service codes. When billing for a service code that requires a report, attach a copy of that report to the claim form.
	Mod	For certain types of services, a two-character modifier must be entered after the service code to fully describe services. See Subchapter 6 of your MassHealth provider manual for the modifiers and descriptions, if applicable.
	Explain Unusual Services or Circumstances	An entry is required in the following cases. *For medical supplies and infusible or injectable medications and injectable devices*: If billing for drugs or injectable devices administered in the office, except vaccines, enter the national drug code (NDC) and the quantity of the drug administered. This information is in addition to the HCPCS code entered on the same line. Use the following qualifiers when reporting NDC units: GR – gram (for creams, ointments, and bulk powders); ML – milliliter (for liquids, suspensions, solutions, and lotions);

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
24C	Explain Unusual Services or Circumstances (cont.)	UN – unit (for tablets, capsules, suppositories, and powder-filled vials); and F2 – international unit (for example, anti-hemophilia factor). If billing for medical supplies, medications, or injectables that are listed in Subchapter 6 of the *Physician Manual* as requiring individual consideration (IC), enter a complete description of the item and the acquisition cost in addition to the quantity dispensed and the NDC, and attach a copy of the supplier's invoice. Invoices submitted with a claim must be dated no more than 18 months before the date of service. One invoice indicating all the items for which payment is requested is acceptable.
24D	Diagnosis Code	Enter the ICD-9-CM diagnosis code for the primary condition. If there is a fourth or fifth digit, it is a required part of the code. Do not delete leading zeros or add trailing zeros. "V" codes are acceptable. "E" or "M" codes are not acceptable.
24E	Charges	Enter the provider's usual and customary fee (amount charged to a person who is not a MassHealth member). *For medical supplies, medications, and injectables*: Enter the actual acquisition cost and attach a copy of the supplier's invoice to the claim. Invoices submitted with a claim must be no more than 18 months before the date of service.
24F	Days or Units	Enter the appropriate number of units billed on the claim line for the service date. When billing for consecutive days of service, enter the total number of days or units within the billing period. When billing for nonconsecutive dates of service, enter "1" for each date of service or unit entered on the claim form. *For anesthesia:* Enter the total number of 15-minute periods (including as one unit any remaining fraction that equals or exceeds five minutes) that make up the beginning and ending clock time for the anesthesia service. Refer to 130 CMR 433.000 for regulations about reporting anesthesia time. If no units are entered, the service is paid at the base rate.

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
24G	Other Paid Amount	Leave this item blank unless the member has other health insurance coverage. Do not enter previous MassHealth payments. Enter any amount received for the service from any source other than MassHealth, and attach a copy of the notice of final disposition from the other payment source to the claim form. This notice may be an explanation of benefits (EOB) or a remittance advice. Any amount entered in Item 24G will be deducted from the MassHealth payment.
25	Authorized Signature	The claim form must be signed by the provider or by an individual designated by the provider to certify that the information entered on the form is correct. Signatures other than handwritten signatures (for example, stamped, typewritten, or mechanically applied) are acceptable. Enter in MMDDYY format the date on which the claim form was completed. This date cannot be before the last date of service on the form.
26	Accept Assignment	Leave this item blank.
27	Total Charge	Leave this item blank.
28	Amount Paid	Leave this item blank.
29	Balance Due	Leave this item blank.
30	Servicing Provider No.	Leave this item blank.
31	Physician or Supplier's Name, Address, Zip Code, Telephone No.	Enter the provider's name, address, and telephone number(s).
	Pay to Provider No.	Leave this item blank.
32	Your Patient's Account No.	Enter the patient account number, if one is assigned. If one is not assigned, enter the member's last name.
33	Billing Agent No.	If this form is being prepared by a billing agent, enter the seven-digit number assigned to the agent. If one was not assigned, leave this item blank.
34	Adjustment/Resubmittal	If the claim is an adjustment or resubmittal, check the appropriate box. Use the resubmittal option for certain previously denied claims over 90 days. Do not make any entry in this item without completing Item 35. For additional information about correcting claims, consult Subchapter 5 of your MassHealth provider manual.

Item-by-Item Instructions for Claim Form No. 5 (cont.)

Item No.	Item Name	Description
35	Former Transaction Control No.	When an entry is required in this item, enter the 10-character transaction control number (TCN) assigned to the original claim. The TCN appears on the remittance advice that listed the original claim as paid or denied. This item is required if either of the boxes in Item 34 is checked. Refer to Part 7 of Subchapter 5 of your MassHealth provider manual before attempting to resubmit or adjust claims. Incorrect use of the TCN may result in denied claims.
36	For Office Use Only	Leave this item blank.